Helen Ward, Rob Miller

CONTRACEPTIVE CHOICE FOR HIV POSITIVE WOMEN

Worldwide an estimated 42 million people are living with HIV/AIDS; 50% of adults with HIV infection are women, the majority having acquired infection via heterosexual sex. HIV itself does not affect fertility, but lower conception rates may occur as a result of behavioural change, existing subfertility, low body mass index, and intercurrent illness, especially tuberculosis. HIV infected women, as other women, may wish to plan pregnancy, limit family size, or avoid pregnancy. Mitchell and Stephens review the contraceptive choices available for women with HIV infection, including the effects of different methods on the risk of sexual transmission of HIV. This article provides a valuable resource for health professionals caring for HIV infected women.

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''OLD PROBLEMS AND MODERN CHALLENGES''—CONTROL OF STIs IN DEVELOPING COUNTRIES

Up to 85% of an estimated 340 million annual new cases of curable STIs occur in developing countries, where they constitute a huge health and economic burden. In reviewing the extent of this burden, with particular emphasis on Africa, Mayaud and Mabey describe the interventions available to reduce the incidence and prevalence of STIs—primary prevention, screening and case finding, case management (using a syndromic approach), targeted interventions for high risk populations, and in some cases (targeted) periodic mass treatment. The authors further identify that the challenge of effective STI control is not just development of new interventions, but also identification of barriers to implementation of existing tools.

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PENILE MYIASIS—A HAZARD OF SLEEPING NAKED?

Myiasis is a disease caused by infestation of body tissues by larvae of several species of fly. Passos *et al* describe myiasis of the penis, caused by *Dermatobia hominis* (human botfly), occurring in a 21 year old Brazilian man. It is likely that he became infested while sleeping naked. The patient developed a painful nodule on the glans which later discharged sero-sanguinous fluid. The lesion was originally misdiagnosed as primary syphilis. A larva of *D hominis* was identified in the lesion. With removal of the larva and antibiotic administration the patient recovered fully. The authors discuss the natural history and diagnosis of this unusual genital infestation.

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HERPES IN EUROPE

Improvements in type specific serological testing methods have facilitated closer inspection of the basic epidemiology of HSV-1 and HSV-2. Pebody and collaborators report from a large European study showing wide variation across the continent. The age standardised prevalence was calculated from serological surveys, and for HSV-1 ranged from 52% (Finland) to 84% (Bulgaria), and for HSV-2 from 4% (England and Wales) to 24% (Bulgaria). HSV-1 did not appear to offer significant protection against HSV-2, but the authors comment that the high proportion of adolescents who remain susceptible to HSV-1 has implications for the presentation and transmission of HSV-2.

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EVIDENCE OF OPTIMISM

Clinical performance is difficult to measure but increasingly important in healthcare systems. Indicators are frequently used, but how should the standards be set? Low and colleagues report the findings of an exercise undertaken by the Clinical Effectiveness Group of the Medical Society for the Study of Venereal Diseases and the Association of Genitourinary Medicine (now merged to form the British Association for Sexual Health and HIV). They developed standards for quality of case management and partner notification in gonococcal and chlamydial infection using two separate methods: reviewing available evidence; and asking practitioners. The practitioners were ambitious and developed much higher standards than the evidence suggested were realistic. Such optimism is encouraging at one level, but shows that great care must be taken or clinicians will set themselves up to fail.

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> ''I don't think, I hardly ever do screening for chlamydia……it just doesn't occur to me.'' See p 209

PRIMARY CARE AND SEXUAL HEALTH

Shifting delivery of sexual health services more to primary care is an objective shared in many countries. Surprisingly little is known about how much treatment and care is provided in such settings, or of the quality of that care. Three papers in this issue address different aspects of this question. Johnston and colleagues (***p 212***) used a routine database in Australia to find out how often GPs managed STI. Not very often: of 303 000 consultations only 521, that is less than 2 per 1000 consultations, were STI diagnoses. In the UK there is wide variation (up to 40-fold) in the frequency of chlamydia testing by different GP practices. McNulty and colleagues (***p 207***) explored this using focus groups, and found that staff in practices where testing was infrequent knew little about the epidemiology and presentation of genital chlamydia, and often thought it was an inner-city problem. High testing practices were those where a doctor or nurse had a special interest or training in sexual health.

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